# 2.0 Cardiac Risk Assessment Information (Enter/Edit)

The Surgical Clinical Nurse Reviewer uses this option to create a new risk assessment for a cardiac patient. Cardiac cases are evaluated differently from non-cardiac cases and the prompts are different. This option is also used to make changes to an assessment that has already been entered.

The example below demonstrates how to create a new risk assessment for cardiac patients and how to use the following sub-option menu.

| | |
|---|---|
| CLIN | *Clinical Information (Enter/Edit)* |
| CATH | *Enter Cardiac Catheterization & Angiographic Data* |
| OP | *Operative Risk Summary Data (Enter/Edit)* |
| CARD | *Cardiac Procedures Requiring CPB (Enter/Edit)* |
| IO | *Intraoperative Occurrences (Enter/Edit)* |
| PO | *Postoperative Occurrences (Enter/Edit)* |
| R | *Resource Data* |
| U | *Update Assessment Status to 'COMPLETE'* |

These eight sub-options are used for entering more in-depth data for a case. Sections 2.1 through 2.8 of this chapter describe each of the sub-options.

**How to Create a New Risk Assessment**

1. First enter a patient name. If the patient has any previous assessments, they will be displayed. An asterisk (*) indicates a cardiac case. A choice is presented to create a new assessment or to edit one of the previously entered assessments. (For a description of editing features, see the end of this chapter.)

2. Choose the operation to report on, then respond Yes to the prompt, "Are you sure that you want to create a Risk Assessment for this surgical case?". Answer Yes (or press the Return key to accept the Yes default) to get to any of the sub-options. If No is the response, the case created in step 1 will not be considered an assessment, although it can appear on some lists, and the computer will return to the "Select Patient" prompt.

3. The screen will clear and present the sub-options menu. Select a sub-option now to enter more in-depth information for the case, or press the Return key to return to the main menu.

## Example: Creating A New Risk Assessment (Cardiac)

```
Select Surgery Risk Assessment Menu Option: C Cardiac Risk Assessment Information
(Enter/Edit)


Select Patient: DOE,BUTCH          03-03-45     333221212       NSC VETERAN


 DOE,BUTCH  333-22-1212

1.   ----     CREATE NEW ASSESSMENT


Select Surgical Case: 1


 DOE,BUTCH   333-22-1212

1. 01-18-95   CORONARY ARTERY BYPASS (COMPLETED)

2. 06-18-93   INGUINAL HERNIA (COMPLETED)



Select Operation: 1

Are you sure that you want to create a Risk Assessment for this surgical
case ?  YES// <RET>
```

## 2.1 Clinical Information (Enter/Edit)

This sub-option is used to enter the clinical information required for a cardiac risk assessment. The computer will present one page with a prompt at the bottom to select one or more items to edit. If it is not necessary to edit any items on the page, press the Return key to proceed to another option.

**About the "Select Clinical Information to Edit" prompt**
At this prompt, enter the item number to be edited. Enter **A,** for All, to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information is entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and gives another opportunity to enter or edit data. If assistance is needed while interacting with the software, enter one or two question marks to receive on-line help.

**Example: Enter Clinical Information**

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CLIN  Clinical
Information (Enter/Edit)


HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------


 1. Height:                              14. Functional Status:
 2. Weight:                              15. PTCI:
 3. Diabetes:                            16. Prior MI:
 4. COPD:                                17. Prior Heart Surgery:
 5. FEV1:                                18. Peripheral Vascular Disease:
 6. Cardiomegaly (X-ray):                19. Cerebral Vascular Disease:
 7. Pulmonary Rales:                     20. Angina (use CCS Class):
 8. Current Smoker:                      21. CHF (use NYHA Class):
 9. Creatinine:    NS   mg/dl           22. Current Diuretic Use:
10. Hemoglobin:    NS    g/dl           23. Current Digoxin Use:
11. Serum Albumin: NS    g/dl           24. IV NTG within 48 Hours:
12. Active Endocarditis:                 25. Preop Use of IABP:
13. Resting ST Depression:               26. Hypertension (Y/N):

------------------------------------------------------------------------------

Select Clinical Information to Edit: A
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------



Patient's Height: 76
Patient's Weight: 210
Diabetes: O  ORAL
History of COPD (Y/N): Y  YES
FEV1 : NS
Cardiomegaly on Chest X-Ray (Y/N): Y  YES
Pulmonary Rales (Y/N): Y  YES
Current Smoker: NEVER  NEVER A SMOKER
Preoperative Serum Creatinine (mg/dl): NS// 1.2
Date Preoperative Serum Creatinine was Performed: 6/6/97
Preoperative Hemoglobin (g/dl): NS
Date Preoperative Hemoglobin was Performed: <RET>
Preoperative Serum Albumin (g/dl): 3.8
Date Preoperative Serum Albumin was Performed: 6/6/97
Active Endocarditis (Y/N): N  NO
Resting ST Depression (Y/N): N  NO
Functional Health Status: INDEPENDENT
PTCA: 1  NONE RECENT
Prior Myocardial Infarction: 1  LESS THAN OR EQUAL TO 7 DAYS PRIOR TO SURGERY
Prior Heart Surgery (Y/N): Y  YES
Peripheral Vascular Disease (Y/N): Y  YES
Cerebral Vascular Disease (Y/N): N  NO
Angina (use CCS Functional Class): IV  CLASS IV
Congestive Heart Failure (use NYHA Functional Class): II  SLIGHT LIMITATION
Current Diuretic Use (Y/N): Y  YES
Current Digoxin Use (Y/N): N  NO
IV NTG within 48 Hours Preceding Surgery (Y/N): Y  YES
Preoperative use of IABP (Y/N): N  NO
History of Hypertension (Y/N): N NO
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                      PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------


 1. Height:               76 in            14. Functional Status:     INDEPENDENT
 2. Weight:               210 lb           15. PTCA:                  NONE RECENT
 3. Diabetes:             ORAL             16. Prior MI:           < OR = 7 DAYS
 4. COPD:                 YES              17. Prior Heart Surgery:          YES
 5. FEV1:                 NS               18. Peripheral Vascular Disease:  YES
 6. Cardiomegaly (X-ray): YES              19. Cerebral Vascular Disease:    NO
 7. Pulmonary Rales:      YES              20. Angina (use CCS Class):       IV
 8. Current Smoker:       NEVER A SMOKER   21. CHF (use NYHA Class):         II
 9. Creatinine:           1.2  mg/dl       22. Current Diuretic Use:         YES
10. Hemoglobin:           NS   mg/dl       23. Current Digoxin Use:          NO
11. Serum Albumin:        3.8  g/dl        24. IV NTG within 48 Hours:       YES
12. Active Endocarditis:  NO               25. Preop Use of IABP:            NO
13. Resting ST Depression: NO              26. History of Hypertension (Y/N): NO

------------------------------------------------------------------------------

Select Clinical Information to Edit: <RET>
```

## 2.2 Enter Cardiac Catheterization & Angiographic Data

This sub-option is used to enter or edit cardiac catheterization and angiographic information for a cardiac risk assessment. The computer will present one page. At the bottom of the page is a prompt to select one or more items to edit. If it is not necessary to edit any items on the page, press the Return key to proceed to another option.

### About the "Select Cardiac Catheterization and Angiographic Information to Edit" prompt

At this prompt, enter the item number to edit. Enter **A,** for All, to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

### Example: Enter Cardiac Catheterization & Angiographic Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CATH  Enter Cardiac
Catheterization & Angiographic Data


HONEYCUTT,B.J. (321-98-4352)        Case #60183                          PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

 1. LVEDP:
 2. Aortic Systolic Pressure:
 3. *PA Systolic Pressure:
 4. *PAW Mean Pressure:

 5. Left Main Stenosis:
 6. LAD Stenosis:
 7. Right Coronary Stenosis:
 8. Circumflex Stenosis:

 9. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo):

10. Mitral Regurgitation:

------------------------------------------------------------------------------

Select Cardiac Catheterization and Angiographic Information to Edit: A
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------


Left Ventricular End-Diastolic Pressure: 56
Aortic Systolic Pressure: 120
PA Systolic Pressure: 30
PAW Mean Pressure: 15
Left Main Stenosis: 65
Left Anterior Descending (LAD) Stenosis: 50
Right Coronary Artery Stenosis: 40
Circumflex Coronary Artery Stenosis: 30
LV Contraction Grade: II  II    0.45-0.54    MILD DYSFUNC.
Mitral Regurgitation: ?
     Enter the code describing presence/severity of mitral regurgitation.
     CHOOSE FROM:
       0        NONE
       1        MILD
       2        MODERATE
       3        SEVERE
       NS       NO STUDY
Mitral Regurgitation: 2  MODERATE
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

 1. LVEDP:                      56 mm Hg
 2. Aortic Systolic Pressure: 120 mm Hg
 3. *PA Systolic Pressure:      30 mm Hg
 4. *PAW Mean Pressure:         15 mm Hg

 5. Left Main Stenosis:         65%
 6. LAD Stenosis:               50%
 7. Right Coronary Stenosis:    40%
 8. Circumflex Stenosis:        30%

 9. LV Contraction Grade  (from contrast
    or radionuclide angiogram or 2D echo): II 0.45-0.54  MILD DYSFUNCTION

10. Mitral Regurgitation:     MODERATE

------------------------------------------------------------------------------
Select Cardiac Catheterization and Angiographic Information to Edit:<RET>
```

## 2.3 Operative Risk Summary Data (Enter/Edit)

This sub-option is used to enter or edit operative risk summary data for a cardiac risk assessment. This option records the physician's subjective estimate of operative mortality. To avoid bias, this should be completed preoperatively. The computer will present one page. At the bottom of the page is a prompt to select one or more items to edit. If it is not necessary to edit any of the items, press the Return key to proceed to another option.

**About the "Select Operative Risk Summary Information to Edit" prompt**
At this prompt, enter the item number to edit. Enter **A,** for All, to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items.

### Example: Operative Risk Summary Data

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: OP  Operative Risk
Summary Data (Enter/Edit)


HONEYCUTT,B.J. (321-98-4352)        Case #60183                          PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

 1. Physician's Preoperative Estimate of Operative Mortality:
 2. ASA Classification:
 3. Surgical Priority:
 4. Operative Death:           NO
 5. Date/Time Operation Began: JUN 18,1997 08:45
 6. Date/Time Operation Ended: JUN 18,1997 14:25
 7. Principle CPT Code:        33510
 8. Other Procedures CPT Code:  ***INFORMATION ENTERED***
 9. Preoperative Risk Factors:  [This field is used to further explain any preoperative risk factors that
cannot be answered above. The maximum length of this field is 130 characters.]
10. Cardiac Surgery to Non-VA facility: NO

------------------------------------------------------------------------------

Select Operative Risk Summary Information to Edit: 1:3
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------



Physician's Preoperative Estimate of Operative Mortality: 32
Date/Time of Estimate of Operative Mortality: JUN 17,1997@18:15
         // <RET>
ASA Class: 3  3-SEVERE DISTURB.
Cardiac Surgical Priority: ?
     Enter the surgical priority that most accurately reflects the acuity of
     patient's cardiovascular condition at the time of transport to the
     operating room.
     CHOOSE FROM:
       1        ELECTIVE
       2        URGENT
       3        EMERGENT (ONGOING ISCHEMIA)
       4        EMERGENT (HEMODYNAMIC COMPROMISE)
       5        EMERGENT (ARREST WITH CPR)
Cardiac Surgical Priority: 3  EMERGENT (ONGOING ISCHEMIA)
Date/Time of Cardiac Surgical Priority:  JUN 17,1997@13:29
         // <RET>
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

 1. Physician's Preoperative Estimate of Operative Mortality: 32%
   A. Date/Time Collected:    JUN 17,1997 18:15
 2. ASA Classification:        3. SEVERE DISTURBANCE
 3. Surgical Priority:         EMERGENT (ONGOING ISCHEMIA)
   A. Date/Time Collected:    JUN 17,1997 09:46
 4. Operative Death:           NO
 5. Date/Time Operation Began: JUN 18,1997 08:45
 6. Date/Time Operation Ended: JUN 18,1997 14:25
 7. Principle CPT Code:        33510
 8. Other Procedures CPT Code: ***INFORMATION ENTERED***
 9. Preoperative Risk Factors:
10. Cardiac Surgery to Non-VA facility: NO


------------------------------------------------------------------------------

Select Operative Risk Summary Information to Edit:<RET>
```

## 2.4 Cardiac Procedures Requiring CPB (Enter/Edit)

This sub-option is used to enter or edit information related to cardiac procedures requiring cardiopulmonary bypass (CPB). The computer will present one page. At the bottom of the page is a prompt to select one or more items to edit. If it is not necessary to edit any items on the page, press the Return key to proceed to another option.

**About the "Select Operative Information to Edit" prompt**
At this prompt, enter the item number to edit. Enter **A,** for All, to respond to every item on the page, or enter a range of numbers separated by a colon (:) to respond to a range of items. Number-letter combinations, such as 16B, can be used to update a field within a group, such as VSD Repair.

Responding No at the category level will cause each item under that category to be answered No. On the other hand, responding Yes at the category level will allow a Yes or No to be entered for each item under that category.

After the information has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

**Example: Enter Cardiac Procedures Requiring CPB**

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: CARD  Cardiac
Procedures Requiring CPB (Enter/Edit)
```

```
HONEYCUTT, B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------
CABG Distal Anastomoses                  14. Cardiac Transplant:
 1. Number with Vein:                    15. Electrophysiologic Procedure:
 2. Number with IMA:                     16. Misc. Cardiac Procedures:
 3. Number with Radial Artery:               A. ASD Repair:
 4. Number with Other Artery:                B. VSD Repair:
 5. Number with Other Conduit:               C. Myxoma Resection:
                                             D. Foreign Body Removal:
 6. Aortic Valve Replacement:                E. Myectomy for IHSS:
 7. Mitral Valve Replacement:                F. Pericardiectomy:
 8. Tricuspid Valve Replacement:             G. Other Tumor Resection:
 9. Valve Repair:                            H. Other Procedure(s):
10. LV Aneurysmectomy:                   17. Minimally Invasive Procedure:
11. Great Vessel Repair (Req CPB):       18. Batista Procedure:
12. Total Ischemic Time:                 19. Incision Type:
13. Total CPB Time:                      20. Convert Off Pump to CPB: NO STUDY/UN
------------------------------------------------------------------------------
Select Operative Information to Edit: A
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------



CABG Distal Anastomoses with Vein: 1
CABG Distal Anastomoses with IMA: 1
CABG Distal Anastomoses with Radial Artery: 0
CABG Distal Anastomoses with Other Artery: 0
CABG Distal Anastomoses with Other Conduit: 0
Aortic Valve Replacement (Y/N): Y  YES
Mitral Valve Replacement (Y/N): N  NO
Tricuspid Valve Replacement (Y/N): N  NO
Valve Repair (Y/N): Y  YES
LV Aneurysmectomy (Y/N): N  NO
Great Vessel Repair, requiring CPB (Y/N): Y  YES
Total Ischemic Time (minutes): 0
Total CPB (Cardiopulmaonary ByPass Time (minutes): 50
Cardiac Transplant (Y/N): N  NO
Electrophysiologic Procedure (Y/N): N  NO
Miscellaneous Cardiac Procedures: N  NO
Minimally Invasive Procedure Used: N  NO
Batista Procedure Used (Y/N): N  NO
Incision Type: FULL THORACOTOMY
Convert Off Pump to CPB: YES-PLANNED
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183                        PAGE: 1
JUN 18,1997   CORONARY ARTERY BIPASS (33510)
------------------------------------------------------------------------------
CABG Distal Anastomoses                        14. Cardiac Transplant: NO
 1. Number with Vein:              1          15. Electrophysiologic Procedure: NO
 2. Number with IMA:               1          16. Misc. Cardiac Procedures: NO
 3. Number with Radial Artery:     0                 A. ASD Repair: NO
 4. Number with Other Artery:      0                 B. VSD Repair: NO
 5. Number with Other Conduit:     0                 C. Myxoma Resection: NO
                                                     D. Foreign Body Removal: NO
 6. Aortic Valve Replacement:      YES               E. Myectomy for IHSS: NO
 7. Mitral Valve Replacement:      NO                F. Pericardiectomy: NO
 8. Tricuspid Valve Replacement:   NO                G. Other Tumor Resection: NO
 9. Valve Repair:                  YES               H. Other Procedure(s): NO
10. LV Aneurysmectomy:             NO         17. Minimally Invasive Procedure: NO
11. Great Vessel Repair (Req CPB): YES        18. Batista Procedure: NO
12. Total Ischemic Time:     0 minutes        19. Incision Type: FULL THORACOTOMY
13. Total CPB Time:          50 minutes       20. Convert Off Pump to CPB: YES-PLANNED
------------------------------------------------------------------------------
Select Operative Information to Edit: <RET>
```

## 2.5 Intraoperative Occurrences (Enter/Edit)

The nurse reviewer uses this option to enter or change information related to intraoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (?) at the "Enter a New Intraoperative Occurrence" prompt.

After an occurrence category has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

### Example: Enter an Intraoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: IO  Intraoperative
Occurrences (Enter/Edit)

HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

There are no Intraoperative Occurrences entered for this case.


Enter a New Intraoperative Occurrence: CARDIAC ARREST REQUIRING CPR
Any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) of
any duration occurring in the operating room, ICU, ward, or out-of-hospital after the
chest has been completely closed and within 30 days following surgery.  Exclude
intentional arrests during cardiac surgery.


Press RETURN to continue: <RET>


HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

1. Occurrence:          CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 2:5


HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

Occurrence Category: CARDIAC ARREST REQUIRING CPR
         // <RET>
ICD Diagnosis Code: 102.8  102.8        LATENT YAWS
         ...OK? YES//<RET>   (YES)
Type of Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

1. Occurrence:          CARDIAC ARREST REQUIRING CPR
2. Occurrence Category: CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:    102.8
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <RET>
```

## 2.6 Postoperative Occurrences (Enter/Edit)

The nurse reviewer uses this option to enter or change information related to postoperative occurrences. Every occurrence entered must have a corresponding occurrence category. For a list of occurrence categories, enter a question mark (?) at the "Enter a New Postoperative Occurrence" prompt.

After an occurrence category has been entered or edited, the terminal display screen will clear and present a summary. The summary organizes the information entered and provides another opportunity to enter or edit data.

### Example: Enter a Postoperative Occurrence

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: PO  Postoperative
Occurrences (Enter/Edit)


HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

There are no Postoperative Occurrences entered for this case.


Enter a New Postoperative Occurrence: CARDIAC ARREST REQUIRING CPR
Any cardiac arrest requiring external or open cardiopulmonary resuscitation (CPR) of
any duration occurring in the operating room, ICU, ward, or out-of-hospital after the
chest has been completely closed and within 30 days following surgery.  Exclude
intentional arrests during cardiac surgery.


Press RETURN to continue: <RET>
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------


1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:
5. Outcome to Date:
6. Date Noted:
7. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: 4:6
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

Treatment Instituted: CPR
Outcome to Date: I  IMPROVED
Date/Time the Occurrence was Noted: 6/19/97  (JUN 19, 1997)
```

```
HONEYCUTT,B.J. (321-98-4352)        Case #60183
JUN 18,1997   CORONARY ARTERY BYPASS (33510)
------------------------------------------------------------------------------

1. Occurrence:            CARDIAC ARREST REQUIRING CPR
2. Occurrence Category:   CARDIAC ARREST REQUIRING CPR
3. ICD Diagnosis Code:
4. Treatment Instituted:  CPR
5. Outcome to Date:       IMPROVED
6. Date Noted:            06/19/97
7. Occurrence Comments:

------------------------------------------------------------------------------

Select Occurrence Information: <RET>
```

## 2.7 Resource Data (Enter/Edit)

The nurse reviewer uses this option to enter, edit or review risk assessment cardiac patient demographic information such as hospital admission, discharge dates and other information related to this surgical episode.

### Example: Resource Data (Enter/Edit)

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: R  Resource Data

DOE,PAUL (223-33-4445)        Case #49413
JUN 18,1997   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
------------------------------------------------------------------------------

Enter/Edit Patient Resource Data

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

Select Number:  (1-2): 1

Are you sure you want to retrieve information from PIMS records ? YES//<RET>

...HMMM, I'M WORKING AS FAST AS I CAN...
```

```
DOE,PAUL (223-33-4445)        Case #49413
JUN 18,1997   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
------------------------------------------------------------------------------

Enter/Edit Patient Resource Data

1. Capture Information from PIMS Records
2. Enter, Edit, or Review Information

Select Number:  (1-2): 2
```

```
DOE,PAUL (223-33-4445)        Case #49413
JUN 18,1997   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
------------------------------------------------------------------------------

1. Hospital Admission Date:            JUN 16, 1997@08:00
2. Hospital Discharge Date:            JUN 30, 1997@08:00
3. Cardiac Catheterization Date:       JUN 17, 1997
4. Time Patient In OR:                 JUN 18, 1997@07:30
5. Time Patient Out OR:                JUN 18, 1997@14:30
6. Date/Time Patient Extubated:
7. Date/Time Discharged from ICU:      JUN 19, 1997@8:30
8. Employment Status Preoperatively:
9. Resource Data Comments:

------------------------------------------------------------------------------

Select number of item to edit: 8
Employment Status Preoperatively: EMPLOYED FULL TIME// NOT  NOT EMPLOYED
```

```
DOE,PAUL (223-33-4445)        Case #49413
JUN 18,1997   CABG X3 USING LSVG TO OMB,LV EXT. OF RCA,LIMA TO LAD (33518)
-------------------------------------------------------------------------------

1. Hospital Admission Date:            JUN 16, 1997@08:00
2. Hospital Discharge Date:            JUN 30, 1997@08:00
3. Cardiac Catheterization Date:       JUN 17, 1997
4. Time Patient In OR:                 JUN 18, 1997@07:30
5. Time Patient Out OR:                JUN 18, 1997@14:30
6. Date/Time Patient Extubated:
7. Date/Time Discharged from ICU:      JUN 19, 1997@8:30
8. Employment Status Preoperatively:   NOT EMPLOYED
9. Resource Data Comments:

-------------------------------------------------------------------------------

Select number of item to edit: <RET>
```

## 2.8 Update Assessment Status to ‘Complete’

Use this option to upgrade the status of an assessment to “Complete”. A complete assessment has enough information for it to be transmitted to the centers where data are analyzed. Only complete assessments are transmitted. After updating the status, the patient’s entire *Surgery Risk Assessment Report* may be printed. This report can be copied to a terminal screen or to a printer.

**Example : Update Assessment Status to COMPLETE**

```
Select Cardiac Risk Assessment Information (Enter/Edit) Option: U  Update Assess
ment Status to 'COMPLETE'


This assessment is missing the following items:

      1. Batista Procedure Used
      2. Minimally Invasive Procedure Technique Used Y/N

Do you want to enter the missing items at this time? NO// YES
BATISTA PROCEDURE USED (Y/N): N  NO
MINIMALLY INVASIVE PROC (Y/N): N  NO

Are you sure you want to complete this assessment ? NO// YES

Updating the current status to 'COMPLETE'...

Do you want to print the completed assessment ?  YES//  NO
```

# 3.0 Print a Surgery Risk Assessment

This option prints an entire *Surgery Risk Assessment Report* for an individual patient. This report can be displayed temporarily on a terminal screen. As the report fills the terminal screen a prompt to press the Return key to continue to the next page will appear. A permanent record can be made by copying the report to a printer. When using a printer, the report is formatted slightly differently from the way it appears on the terminal.

**Example 1: Print Surgery Risk Assessment for a Non-Cardiac Case**

```
Select Surgery Risk Assessment Menu Option: P  Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO//  <RET>


Select Patient: DISNEY,WALT         05-07-23     321323214     NO     NSC VET
ERAN

DISNEY,WALT  321-32-3214

1. 06-23-98   CHOLEDOCHOTOMY (TRANSMITTED)

2. 01-20-95   EXPLORATORY LAP, GRAM PATCH OF DUODENAL ULCER (TRANSMITTED)



Select Surgical Case: 1

Print the Completed Assessment on which Device: [Select Print Device]
```

..... *printout follows* .....

```
VA NON-CARDIAC RISK ASSESSMENT             Assessment: 112            PAGE 1
FOR DISNEY,WALT  321-32-3214 (TRANSMITTED 08/10/98)
================================================================================

Medical Center: ISC-BIRMINGHAM, AL
Age:            39                      Operation Date:    JUN 23, 1998
Sex:            MALE                    Race:  WHITE, NOT OF HISPANIC ORIGIN

Transfer Status: NOT TRANSFERRED
Observation Admission Date:                    JUN 23,1998  08:10
Observation Discharge Date:                    JUN 24,1998  07:00
Observation Treating Specialty:                SURGICAL OBSERVATION
Hospital Admission Date:                       JUN 24,1998  07:01
Hospital Discharge Date:                       JUN 30,1998  11:22
Admitted/Transferred to Surgical Service:      JUN 24,1998  07:01
Discharged/Transferred to Chronic Care:        JUN 30,1998  11:22
In/Out-Patient Status:                         INPATIENT
--------------------------------------------------------------------------------

                            PREOPERATIVE INFORMATION


GENERAL:                      NO        HEPATOBILIARY:                  NO
Diabetes Mellitus:            NO        Ascites:                        NO
Current Smoker W/I 1 Year:    NO
Pack/Years:                   0
ETOH > 2 Drinks/Day:          NO        CARDIAC:                        NO
Dyspnea:                      NO        CHF Within 1 Month:             NO
DNR Status:                   NO
Functional Status:  INDEPENDENT         RENAL:                          NO
                                        Acute Renal Failure:            NO
PULMONARY:                    NO        Currently on Dialysis:          NO
Ventilator Dependent:         NO
History of Severe COPD:       NO
Current Pneumonia:            NO

CENTRAL NERVOUS SYSTEM:       NO        NUTRITIONAL/IMMUNE/OTHER:       NO
Impaired Sensorium:           NO        Disseminated Cancer:            NO
Coma:                         NO        Open Wound:                     NO
Hemiplegia:                   NO        Steroid Use for Chronic Cond.:  NO
History of TIAs:              NO        Weight Loss > 10%:              NO
CVA/Residual Neuro Deficit:   NO        Bleeding Disorders:             NO
CVA/No Neuro Deficit:         NO        Transfusion > 4 RBC Units:      NO
Tumor Involving CNS:          NO        Chemotherapy W/I 30 Days:       NO
                                        Radiotherapy W/I 90 Days:       NO
                                        Preoperative Sepsis:            NO


                        OPERATION DATE/TIMES INFORMATION

              Date/Time Patient in OR: JUN 23,1998  06:00
            Date/Time Operation Began: JUN 23,1998  06:15
            Date/Time Operation Ended: JUN 23,1998  07:05
          Date/Time Patient Out of OR: JUN 23,1998  07:15
     Anesthesia Care Start Date/Time: JUN 23,1998  06:02
       Anesthesia Care End Date/Time: JUN 23,1998  07:15
            PACU Discharge Date/Time: JUN 23,1998  07:30
```

OPERATIVE INFORMATION

Surgical Specialty: GENERAL(OR WHEN NOT DEFINED BELOW)

Principal Operation: CHOLEDOCHOTOMY
Principal CPT Code: 47425

Concurrent Procedure:
CPT Code:
PGY of Primary Surgeon: 0
Emergency Case (Y/N): NO
Major or Minor: MAJOR
Wound Classification: CLEAN/CONTAMINATED
ASA Classification: 2. MILD DISTURBANCE
Anesthesia Technique: GENERAL
Airway Trauma: NOT ENTERED
Airway Index: NOT ENTERED
RBC Units Transfused: 0

PREOPERATIVE LABORATORY TEST RESULTS

| | | |
|---|---|---|
| Serum Sodium: | 145 | (JUN 22,1998) |
| Serum Creatinine: | 1.1 | (JUN 22,1998) |
| BUN: | 22 | (JUN 22,1998) |
| Serum Albumin: | 3.5 | (JUN 22,1998) |
| Total Bilirubin: | .7 | (JUN 22,1998) |
| SGOT: | 22 | (JUN 22,1998) |
| Alkaline Phosphatase: | 66 | (JUN 22,1998) |
| White Blood Count: | 9.1 | (JUN 22,1998) |
| Hematocrit: | 39.4 | (JUN 22,1998) |
| Platelet Count: | 278 | (JUN 22,1998) |
| PTT: | 27.4 | (JUN 22,1998) |
| PT: | 11.9 | (JUN 22,1998) |

POSTOPERATIVE LABORATORY RESULTS

* Highest Value
** Lowest Value

| | | |
|---|---|---|
| * Serum Sodium: | 148 | (JUN 28,1998) |
| ** Serum Sodium: | 139 | (JUN 25,1998) |
| * Potassium: | 4.8 | (JUN 28,1998) |
| ** Potassium: | 3.7 | (JUN 25,1998) |
| * Serum Creatinine: | 1.3 | (JUN 25,1998) |
| * CPK: | NS | |
| * CPK-MB Band: | NS | |
| * Total Bilirubin: | .9 | (JUN 26,1998) |
| * White Blood Count: | 13.8 | (JUN 24,1998) |
| ** Hematocrit: | 36.2 | (JUN 29,1998) |
| * Troponin I: | NS | |
| * Troponin T: | NS | |

```
VA NON-CARDIAC RISK ASSESSMENT             Assessment: 112            PAGE 3
FOR DISNEY,WALT  321-32-3214 (TRANSMITTED 08/10/98)
================================================================================

                            OUTCOME INFORMATION

  Postoperative Diagnosis Code (ICD9): 550.92  BILAT INGUINAL HERNIA
Length of Postoperative Hospital Stay: 7 DAYS
                         Date of Death:
           Return to OR Within 30 Days: NO


                      PERIOPERATIVE OCCURRENCE INFORMATION

WOUND OCCURRENCES:                YES     CNS OCCURRENCES:                  NO
Superficial Infection:         06/25/98   Stroke/CVA:                       NO
Deep Wound Infection:             NO      Coma > 24 Hours:                  NO
Wound Disruption:                 NO      Peripheral Nerve Injury:          NO


URINARY TRACT OCCURRENCES:        NO      CARDIAC OCCURRENCES:              YES
Renal Insufficiency:              NO      Arrest Requiring CPR:             NO
Acute Renal Failure:              NO      Myocardial Infarction:            NO
Urinary Tract Infection:          NO      * 427.89 CARDIAC DYSRHYTHM     06/23/98


RESPIRATORY OCCURRENCES:          NO      OTHER OCCURRENCES:                NO
Pneumonia:                        NO      Ileus/Bowel Obstruction:          NO
Unplanned Intubation:             NO      Bleeding/Transfusions:            NO
Pulmonary Embolism:               NO      Graft/Prosthesis/Flap Failure:    NO
On Ventilator > 48 Hours:         NO      DVT/Thrombophlebitis:             NO
                                          Systemic Sepsis:                  NO

* indicates Other (ICD9)
```

## Example 2: Print Surgery Risk Assessment for a Cardiac Case

```
Select Surgery Risk Assessment Menu Option: P  Print a Surgery Risk Assessment

Do you want to batch print assessments for a specific date range ? NO//  <RET>


Select Patient: R9922  RIPROCK,DASH         03-03-34     234189922     NO     SC
 VETERAN
```

```
RIPROCK,DASH  234-18-9922

1. 08-01-97   * CABG X3 (1A,2V), ARTERIAL GRAFTING (TRANSMITTED)

2. 03-27-97   INGUINAL HERNIA (TRANSMITTED)

3. 07-03-95   PULMONARY LOBECTOMY (TRANSMITTED)



Select Surgical Case: Select Surgical Case: 1

Print the Completed Assessment on which Device: [Select Print Device]
```

*..... printout follows .....*

VA CARDIAC SURGERY RISK ASSESSMENT PROGRAM

Patient: RIPROCK,DASH  234-18-9922 Surgery Date: 08/01/97
Assessment Number: 28428 Hospital Number: 521
Cardiac Surgery Contracted to Non-VA Facility: NO

I. CLINICAL DATA

| | | | |
|---|---|---|---|
| Gender: | MALE | Resting ST Depression: | NO |
| Age: | 63 | Functional Status: | INDEPENDENT |
| Height: | 68 in | PTCI: | NONE RECENT |
| Weight: | 95 kg | Prior MI: | NONE |
| Diabetes: | NO | Prior Heart Surgery: | NO |
| COPD: | YES | Peripheral Vascular Disease: | NO |
| FEV1: | 1.5 liters | Cerebral Vascular Disease: | NO |
| Cardiomegaly (X-ray): | NO | Angina (use CCS Class): | III |
| Pulmonary Rales: | NO | CHF (use NYHA Class): | II |
| Current Smoker: | NEVER A SMOKER | Current Diuretic Use: | NO |
| Creatinine: | 1 mg/dl | Current Digoxin Use: | NO |
| Hemoglobin: | 15.3 g/dl | IV NTG 48 Hours Preceding Surgery: | NO |
| Serum Albumin: | NO g/L | Preop Use of IABP: | NO |
| Active Endocarditis: | NO | Hypertension: | NO |

II. CARDIAC CATHETERIZATION AND ANGIOGRAPHIC DATA

Cardiac Catheterization Date:07/24/97

| | | | |
|---|---|---|---|
| LVEDP: | 12 mm Hg | Left Main Stenosis: | 40% |
| Aortic Systolic Pressure: | 100 mm Hg | LAD Stenosis: | 80% |
| *PA Systolic Pressure: | NS mm Hg | Right Coronary Stenosis: | 90% |
| *PAW Mean Pressure: | NS mm Hg | Circumflex Stenosis: | 0% |

Mitral Regurgitation: NONE

LV Contraction Grade (from contrast or radionuclide angiogram or 2D Echo):

| Grade | Ejection Fraction Range | Definition |
|---|---|---|
| II | 0.45-0.54 | MILD DYSFUNCTION |

III. OPERATIVE RISK SUMMARY DATA (Operation Began: 08/01/97 11:05)
Physician's Preoperative (Operation Ended: 08/01/97 16:50)
Estimate of Operative Mortality: 5% (08/07/00 06:51)
ASA Classification: 4-LIFE THREAT
Surgical Priority: ELECTIVE (07/31/97 08:37)
Principal CPT Code: 33518
Other Procedures CPT Codes: 33533-82
Preoperative Risk Factors:

IV. OPERATIVE DATA
Incision Type: FULL THORACOTOMY

A. Cardiac Procedures Requiring Cardiopulmonary Bypass

| | | | |
|---|---|---|---|
| CABG Distal Anastomoses | | Cardiac Transplant: | NO |
| Number with Vein: | 2 | Electrophysiologic Procedure: | NO |
| Number with IMA: | 1 | Misc. Cardiac Procedures | |
| Number with Radial Artery: | 0 | ASD Repair: | NO |
| Number with Other Artery: | 0 | VSD Repair: | NO |
| Number with Other Conduit: | 0 | Myxoma Resection: | NO |
| Aortic Valve Replacement: | NO | Foreign Body Removal: | NO |
| Mitral Valve Replacement: | NO | Myectomy for IHSS: | NO |
| Tricuspid Valve Replacement: | NO | Pericardiectomy: | NO |
| Valve Repair: | NO | Other Tumor Resection: | NO |
| LV Aneurysmectomy: | NO | Minimally Invasive Procedure: | NO |
| Great Vessel Repair (Req CPB): | NO | Batista Procedure: | NO |
| Total Ischemic Time (minutes): | 34 | Other Procedure(s): | NO |
| Total CPB Time (minutes): | 125 | Convert Off Pump to CPB: | YES-PLANNED |

B. Operative Death: NO Date of Death:

```
RIPROCK,DASH  234-18-9922
-------------------------------------------------------------------------------

   C. Perioperative (30 day) Occurrences
      Perioperative MI:                  YES Reoperation for Bleeding:      NO
      Endocarditis:                      NO  On Ventilator > or = 48 Hours: NO
      Renal Failure Requiring Dialysis:  NO  Repeat Cardiopulmonary Bypass: NO
      Low Cardiac Output > or = 6 Hours: NO  Coma > or = 24 Hours:          NO
      Mediastinitis:                     NO  Stroke/CVA:                    NO
      Cardiac Arrest Requiring CPR:      NO  Trachestomy:                   YES
                                             Mechanical Circulatory Support:YES
V. RESOURCE DATA
     Time Patient In  OR:          08/01/97 10:20
     Time Patient Out OR:          08/01/97 16:58
     Hospital Admission Date:      07/31/97 09:59
     Hospital Discharge Date:      08/09/97 15:08
     Date and Time Patient Extubated: 07/03/00 13:31
     Date and Time Patient Discharged from ICU: 01/27/00 10:00
     Resource Data Comments:

VI. Socioeconomic Data
     Employment Status Preoperatively: NOT EMPLOYED


***  End of report for RIPROCK,DASH    234-18-9922 assessment #28428  ***
```

# 6.0 Print 30 Day Follow-up Letters

The Surgical Clinical Nurse Reviewer uses this option to automatically print a letter, or a batch of letters, addressed to a specific patient or patients.

**About the "Do you want to print the letter for a specific assessment?" prompt**

Respond Yes to this prompt in order to print a follow-up letter for a single assessment. The computer will ask you to select the patient and case for which the letter will be printed. See Example 1 below.

Respond No to this prompt if you wish to print a batch of follow-up letters for surgical cases within a date range. The computer will ask for the beginning and ending dates of the date range for which the letters will be printed. See Example 2 on the following pages.

**Example 1: Print a Single Follow-up Letter**

```
Select Surgery Risk Assessment Menu Option: F  Print 30 Day Follow-up Letters

Do you want to edit the text of the letter? NO// <RET>

Do you want to print the letter for a specific assessment ?  YES// <RET>


Select Patient:      HONEYCUTT,B.J.      03-03-30     321984352     SC VETERAN

 HONEYCUTT,B.J.  321-98-4352

1. 06-18-97   CORONARY ARTERY BYPASS (INCOMPLETE)

2. 01-25-97   PULMONARY LOBECTOMY (TRANSMITTED)



Select Surgical Case: 1

Print 30 Day Letters on which Device: [Select Print Device]
```

*..... printout follows .....*